Department of Veterans Affairs
Office of Inspector General
April 2016 Highlights

CONGRESSIONAL TESTIMONY

Two Years After Phoenix, Assistant Inspector General for Audits and Evaluations (Designee) Tells House Committee that Problems with Access to Care Persist

Larry M. Reinkemeyer, Assistant Inspector General for Audits and Evaluations (Designee), testified before the Committee on Veterans' Affairs, United States House of Representatives, at a hearing titled "A Continued Assessment of Delays in Veterans' Access to Health Care" on the Office of Inspector General's (OIG) recent work in this area. Mr. Reinkemeyer discussed recently completed and ongoing OIG work evaluating the extent to which veterans are able to receive timely care. He explained that the results of OIG's completed work are consistent—VA continues to face challenges in providing timely access to care and managing consult appointments at various points of service. He also noted that a number of OIG Hotline contacts continue to allege inappropriate practices by Veterans Health Administration (VHA) staff that undermine the integrity and reliability of wait time metrics as well as that VHA's initiatives to provide veterans community care are not working. Mr. Reinkemeyer told the Committee that the administration of its purchased care programs is a major challenge for VHA, in part because VHA schedulers and their supervisors do not follow established VHA scheduling guidance. Mr. Reinkemeyer was accompanied by Mr. Gary Abe, Deputy Assistant Inspector General for Audits and Evaluations.

[Click here to access testimony.]

OIG REPORTS

Audit of VA's Conference Management for Fiscal Year 2014

In September 2012, OIG issued an *Administrative Investigation of the Fiscal Year (FY) 2011 Human Resources Conferences in Orlando, Florida* (Report No. 12-02525-291), which identified inadequate controls resulting in wasteful spending. OIG conducted this audit of FY 2014 conferences to assess the adequacy of the actions VA took to address identified control weaknesses. OIG identified policy and oversight weaknesses that could undermine the cost effectiveness of conferences and increase the risk of inappropriate spending. VA organizations did not comply with policy for 11 of 12 randomly selected FY 2014 conferences. VA organizations did not prepare Conference Packages in accordance with policy for 10 conferences with budgets totaling approximately $11.6 million. VA organizations also did not prepare Final Conference Reports in accordance with policy for 11 of 12 conferences, with expenditures totaling approximately $7.9 million. Weaknesses in policy implementation occurred because VA did not issue adequate guidance or implement adequate oversight procedures to ensure VA organizations submitted Conference Packages and Final Conference Reports compliant with VA policy. In addition, VA did not provide adequate accountability to ensure that VA organizations complied with conference policies. As a result, these weaknesses contributed to VA reporting approximately

$3.9 million in conference expenditures to Congress that could not be adequately traced to source documentation to verify their accuracy and appropriateness.
[Click here to access report.]

Review of Alleged Noncompliance With Section 508 of the Rehabilitation Act on MyCareer@VA Website
OIG evaluated the merits of an allegation that VA launched an enhanced version of its MyCareer@VA website even though it was not compliant with Section 508 of the Rehabilitation Act of 1973. OIG substantiated the allegation and found that VA Learning University (VALU) project officials did not address nearly 200 known Section 508 compliance issues and did not seek certification of compliance prior to the deployment of the website. Therefore, they failed to ensure individuals with disabilities had access to information and data on the MyCareer@VA website comparable to those who do not have disabilities, as required by law. Despite no evidence to show testing was complete or a certification of compliance, VALU certified acceptance of all deliverables and deployed the website in November 2014. OIG also determined VALU added work, at a cost of $34,011, to the follow-on contract with a current contractor to remedy the outstanding Section 508 noncompliance issues. The deployment of the website prior to the determination of Section 508 compliance occurred because VA policy is not specific regarding Electronic Information and Technology (EIT) compliance with Section 508 requirements. In addition, OIG found that VALU management did not provide adequate oversight of the project. OIG recommended the Assistant Secretary for Human Resources and Administration (HR&A) complete testing of the MyCareer@VA website, address outstanding issues, and seek certification for compliance with Section 508 requirements. OIG also recommended the Assistant Secretary for HR&A take steps to improve controls over ensuring the products VALU develops are Section 508 compliant. In addition, OIG recommended the Assistant Secretary for Information and Technology strengthen VA policy for ensuring EIT products are Section 508 compliant. **[Click here to access report.]**

Healthcare Inspection – Restraint Use, Failure To Provide Care, and Communication Concerns, Bay Pines VA Healthcare System, Bay Pines, Florida
OIG conducted an inspection at the request of Congressman Daniel Webster to assess the merit of allegations that staff inappropriately restrained a patient both physically and chemically; failed to provide anticoagulation medications (Coumadin), fluids, food, and nursing/medical care; and failed to effectively communicate with the patient's family at the Bay Pines Healthcare System (facility), Bay Pines, FL. OIG found that the patient was not inappropriately restrained during a computed tomography (CT) scan. CT technicians placed straps during the procedure for patient safety and to avoid sudden patient movement. OIG substantiated that during his Emergency Department (ED) and inpatient stay, the patient was physically restrained on three occasions due to his combativeness and attempts to interfere with medically necessary treatments. Nursing documentation of the use of restraints was consistent with facility policy; however, OIG did not find a physician's order for the episode of restraint use when in the ED. OIG did not substantiate that the patient failed to receive care. The patient was admitted to a constant observation room on a medical unit. Staff was continuously present to

immediately assist the patient if needed. OIG did not substantiate that the patient was not provided Coumadin because the facility did not have the medication in stock. The patient's medication administration records showed appropriate adjustments of the times and doses of Coumadin. OIG substantiated that two patient advocates failed to act professionally when communicating with the patient's family. OIG did not substantiate that facility staff refused to release the patient's electronic health record to the family or that the electronic health record was altered. OIG substantiated that facility staff failed to effectively communicate with the patient's family on multiple occasions. **[Click here to access report.]**

Review of Potential Inappropriate Split Purchasing at VA New Jersey Health Care System

In April 2014, OIG's Office of Investigations briefed VA New Jersey Health Care System (VANJHCS) leadership regarding the results of a criminal investigation of purchase card abuse in the Engineering Service. OIG determined whether inappropriate split purchasing occurred in services other than the Engineering Service at VANJHCS. OIG found the practice of inappropriate split purchasing extended beyond the Engineering Service at VANJHCS. OIG determined VANJHCS employees made inappropriate split purchases in 64 of the 76 purchase card transactions (84 percent) reviewed totaling $125,270. This included 19 purchase cardholders working in 6 different services. Based on the results of OIG's sample, OIG estimated that VANJHCS staff inappropriately made about 4,750 split purchases totaling approximately $8.9 million from December 2012 through May 2014. This occurred because of a disregard for internal controls that are an integral part of every Federal Government purchase card program. Additionally, management did not provide effective oversight and did not hold VANJHCS purchase cardholders, supervisors, and approving officials accountable for policy violations. OIG estimated that split purchasing resulted in approximately $8.9 million in unauthorized commitments and increased the risk of fraud, waste, and abuse of taxpayer resources at VANJHCS. The lack of oversight and strong controls prevented VANJHCS management from determining whether VANJHCS received all purchased goods and services. Management needs to take immediate corrective action and make long-term improvements to ensure sound financial stewardship of taxpayer resources. OIG recommended the Interim Director of Veterans Integrated Service Network (VISN) 3 ensure VANJHCS complies with VA purchase card program policies, including stronger management oversight. The Interim Director of VISN 3 concurred with our recommendations and provided plans for corrective action. OIG will monitor planned actions and follow up on their implementation.
[Click here to access report.]

Review of Alleged Lack of Audit Logs for the Veterans Benefits Management System

In April 2015, OIG received an anonymous allegation that the Veterans Benefits Administration (VBA) failed to integrate suitable audit logs into the Veterans Benefits Management System (VBMS). OIG substantiated the allegation that VBA failed to integrate suitable audit logs that clearly reported all security violations occurring in VBMS. OIG tested the existence and accuracy of audit logs by having 17 employees at

3 VA Regional Offices (VAROs) attempt to access same station veteran employee compensation claims in VBMS. Although audit logs identified security violations for 15 of the 17 employees, the logs did not show that the security violations occurred within VBMS. Instead, the audit logs indicated that the violations occurred in the Share application used by VARO employees or an unknown system. The other two employees did not appear on the audit logs; we could not determine why this happened. This occurred because VBA officials did not develop sufficient system requirements to ensure that audit logs exist and are accessible to Information Security Officers (ISO). As a result, ISOs were unable to effectively detect, report, and respond to security violations occurring within VBMS. Until VBA resolves this issue, its VAROs will be more susceptible to fraudulent compensation claims processing. OIG recommended the Acting Under Secretary for Benefits (USB) develop system requirements for integrating audit logs into VBMS. OIG also recommended the Assistant Secretary for Information and Technology integrate audit logs into VBMS based on the requirements provided by the Acting USB. Finally, OIG recommended the Acting USB test the audit logs to ensure the logs capture all potential security violations. The Acting USB and the Assistant Secretary for Information and Technology concurred with our recommendations and provided acceptable corrective action plans. OIG will monitor their implementation. The Acting USB also provided technical comments, which OIG took into consideration. **[Click here to access report.]**

Review of Alleged Shredding of Claims-Related Evidence at VARO Los Angeles, California

This is the final report that replaced the Interim Report published under this same title on August 17, 2015. This report is reprinted and includes comments and an action plan from VARO Los Angeles, CA. OIG substantiated that VARO Los Angeles staff were not following VBA's policy on management of veterans' and other Governmental paper records. OIG found nine pieces of claims-related mail that VARO staff failed to properly process. Eight of the documents had the potential to affect veterans' benefits, while one had no effect on a veteran's benefits. Although OIG could not substantiate that the VARO inappropriately shredded some claims-related documents, OIG found sufficient evidence to conclude the VARO staff likely would have inappropriately shredded the nine documents found. OIG's review determined that VARO Los Angeles' implementation of VBA's established processes for the disposition of paper records was not adequate. OIG found that the VARO Los Angeles' Records Management Officer (RMO) position was vacant from August 2014 until the inspection in February 2015. This was because the VARO's Assistant Director had determined that it was not necessary to fill the RMO position when the incumbent was promoted. Not filling the RMO position eliminated the final certification in the VARO's authorized shredding process, which VBA established to prevent improper shredding of claims-related documents. If not for OIG's review, it is likely that the VARO staff would have inappropriately destroyed these nine claims-related documents OIG found. OIG recommended the VARO Director implement a plan and provide training to ensure all VARO staff comply with VBA's policy for handling, processing, and protection of claims-related documents and other Government records. OIG also recommended that the VARO Director take proper action on the eight cases that had the potential to affect

veterans' benefits. OIG recommended the VARO Director implement a plan and assess the effectiveness of training to ensure VARO staff comply with VBA's policy for handling, processing, and protection of claims-related documents and other Governmental records. OIG also recommended that the VARO Director take proper action on the eight cases that had the potential to affect veterans' benefits. The VARO Director concurred with the recommendations. OIG will follow up as required. **[Click here to access report.]**

Review of Claims-Related Documents Pending Destruction at VAROs

In January 2015, OIG received an anonymous allegation that VARO Los Angeles staff were inappropriately shredding mail related to veterans' disability compensation claims. OIG could not substantiate Los Angeles VARO staff inappropriately shredded claims-related documents prior to our review. However, OIG identified that VARO Los Angeles' staff were not following VBA policy on the management of veterans' and other Governmental paper records. In August 2015, OIG made recommendations to the VARO Los Angeles Director and published the interim report on August 17, 2015. OIG then conducted unannounced random inspections at 10 other VAROs to determine if this was a systemic issue. Those 10 sites were Atlanta, GA; Baltimore, MD; Chicago, IL; Houston, TX; New Orleans, LA; Oakland, CA; Philadelphia, PA; Reno, NV; San Juan, PR; and St. Petersburg, FL. OIG focused this review on the improper destruction of veterans' claims-related documents at those 10 VAROs. OIG found VBA's controls were not effective to prevent VARO staff from potentially destroying claims-related documents. OIG identified 69 of 155 claims-related documents improperly scheduled for destruction, which staff at 6 of the 10 VAROs had not properly associated with veterans' claims folders. Two of these documents affected benefits, 9 had the potential to affect benefits, and 58 did not affect benefits, but were still required to be included in the veterans' claims folders or VBA's electronic systems and could have been destroyed thereafter. As OIG identified problems at 6 of the 10 VAROs, OIG concluded this is a systemic issue within VBA. Noncompliance with policy, inadequate controls, and outdated guidance can lead to the potential destruction of claims-related documents. Both VARO staff and management found VBA's policy confusing and did not always receive annual training as required. Further, records management staff did not consistently review documents or maintain violation logs. These actions put documents at risk for inappropriate destruction, which could result in loss of claims and medical evidence, incorrect decisions, and delays in claims processing. OIG recommended the Acting USB ensure VARO compliance with policy, update and clarify policy and procedures, and provide training where needed. The Acting USB concurred with OIG's recommendations. Management's planned actions are responsive and OIG will follow up as required. **[Click here to access report.]**

Review of VBA's Alleged Inappropriate Prioritization of Appeals at VARO Roanoke, Virginia

OIG received an anonymous allegation that staff at the Roanoke VARO were prioritizing the processing of newer appeals before older appeals, resulting in thousands of incomplete appeals dating back from 2010 to 2013. OIG substantiated the allegation that Roanoke VARO appeals staff focused on completing newer appeals instead of

processing older appeals. As of June 4, 2015, Roanoke VARO had 12,890 appeals pending at various stages of the appeals process, of which 3,350 dated back from October 2008 through FY 2013. OIG interviewed 14 of Roanoke's 23 appeals staff and 13 of them stated they primarily focused their FY 2014 efforts on working the newer appeals with fewer issues. Another indicator that Roanoke VARO appeals staff focused on completing newer appeals was the number of completed appeals that were less than a year old. At the Roanoke VARO, the number of appeals completed in less than a year increased by 16 percent, from 66 percent in FY 2013 to 82 percent of the appeals completed in FY 2014. This compared to an increase of 1 percent at the Atlanta VARO, 2 percent at the St. Petersburg VARO, and 4 percent at the Winston-Salem VARO. This occurred because Roanoke VARO leadership did not follow workload management plans, which required that appeals staff prioritize their work based on the appeals with the longest days pending. Instead, as directed by the Southern Area Office Director to reduce appeals inventory, the Roanoke VARO's management implemented a Notice of Disagreement reduction plan that focused on processing less complex, newly initiated appeals. OIG recommended that the Roanoke VARO Director ensure that leadership and appeals staff follow the workload management plan to prioritize work based on the appeals pending the longest. The Roanoke VARO Director concurred with OIG's finding and recommendation. Based on actions already implemented, OIG considered the recommendation closed. **[Click here to access report.]**

Review of Alleged Data Manipulation of Appealed Claims at VA Regional Office Wichita, Kansas

In April 2015, OIG received an allegation that Wichita VARO management instructed staff to input inaccurate data when entering Notices of Disagreement (NOD) into the Veterans Appeals Control and Locator System (VACOLS). Allegedly, VARO staff entered inaccurate data to improve timeliness measures associated with appealed claims processing actions. The VBA uses VACOLS, an electronic records system, to track and manage its appeals workloads. The effectiveness of tracking appeals is dependent upon the accuracy and timeliness of the information entered in VACOLS. OIG substantiated the allegation that VARO management instructed staff to enter inaccurate data when recording NOD information into VACOLS rather than entering the actual diagnostic code for the disability or disabilities being appealed, as required. OIG found that in all 36 appealed claims, staff did not follow VBA policy when entering the NODs in VACOLS. OIG could not determine whether VARO management took these actions to improve timeliness measures. Data integrity issues identified at the Wichita VARO occurred because of the lack of management oversight and the subsequent conflicting guidance provided by Compensation Service that required VARO staff to enter incomplete and/or inaccurate information in VACOLS. As a result, VARO staff did not always update VACOLS with accurate information. This may have resulted in veterans not having received the correct information regarding their claims. In addition, inaccurate claims information in VBA's system of records would result in unreliable appeals workload reporting, as well as an inefficient research and inaccurate responses to inquiries. OIG recommended the Wichita VARO Director take action to correct the 36 NODs established in VACOLS and implement a plan to provide adequate oversight to ensure staff establish NODs using accurate data. OIG recommended the Acting USB

develop a plan to notify staff at its 56 VAROs of the modified policy, effective July 29, 2015, to ensure correct processing of an appellate claim. The Acting USB and VARO Director concurred with our findings and the corrective actions were responsive to the recommendations. OIG considered Recommendation 1 closed and will follow up as required on the remaining recommendations. **[Click here to access report.]**

Inspection of VA Regional Office, Montgomery, Alabama

VBA has 56 VAROs that process disability claims and provide services to veterans. OIG evaluated the Montgomery, AL, VARO to see how well it accomplishes this mission. OIG sampled claims considered at increased risk of processing errors; thus, these results do not represent the overall accuracy of disability claims processing at this VARO. VARO staff did not accurately process 13 of the 47 disability claims (28 percent) reviewed, resulting in 77 improper payments to 6 veterans totaling $89,853. The 13 cases with errors related to temporary 100 percent disability evaluations. Most of the errors occurred because VARO staff delayed scheduling medical reexaminations despite receiving reminder notifications—taking on average 1 year and 3 months to do so. All 13 traumatic brain injury claims VARO staff completed from January to June 2015 were accurate. In addition, all four Special Monthly Compensation and ancillary benefits claims completed by VARO staff from July 2014 through June 2015 were accurately processed. VARO staff established the correct dates of claim for 30 cases reviewed in the electronic record. However, 10 of the 30 benefits reduction cases OIG reviewed had processing delays. Generally, the errors related to prioritization of workload. Effective management of this workload can reduce the risk of improper payments and provide better stewardship of taxpayer funds. OIG recommended the VARO Director implement plans to ensure staff take timely action to schedule required medical re-examinations and to review the 15 temporary 100 percent disability evaluations remaining from the inspection universe. OIG also recommended the Acting USB implement a time frame in which staff are required to schedule medical re-examinations after receiving reminder notifications. Furthermore, OIG recommended the VARO Director implement a plan to prioritize actions related to benefits reductions to minimize improper payments to veterans. The VARO Director concurred with OIG's recommendations. The Acting USB agreed the timely scheduling of medical examinations promotes efficiency and financial stewardship; however, VBA did not reinstate a timeliness goal. OIG determined the planned actions lacked urgency and financial stewardship. OIG will follow-up as required.
[Click here to access report.]

Combined Assessment Program Reviews

In April 2016, OIG published eight Combined Assessment Program (CAP) reviews and two summary reports containing OIG findings for the facilities listed below. The purpose of the CAP reviews was to evaluate selected health care facility operations. Topics reviewed may vary due to differences in services provided at each facility, the need to follow up on previous CAP findings, or the rotation of CAP review topics over time. The reviews covered the following 13 activities:

(1) Advance Directives
(2) Quality, Safety, and Value
(3) Environment of Care
(4) Medication Management
(5) Suicide Prevention Program
(6) Alcohol Use Disorder Care
(7) Coordination of Care
(8) Computed Tomography Radiation Monitoring
(9) Quality Management
(10) Mammography Services
(11) Mental Health Residential Treatment Program
(12) Evaluation of Emergency Airway Management
(13) Evaluation of Safe Medication Storage Practices

Tuscaloosa VA Medical Center, Tuscaloosa, Alabama
Carl Vinson VA Medical Center, Dublin, Georgia
Kansas City VA Medical Center, Kansas City, Missouri
Fargo VA Health Care System, Fargo, North Dakota
Eastern Oklahoma VA Health Care System, Muskogee, Oklahoma
James H. Quillen VA Medical Center, Mountain Home, Tennessee
Hunter Holmes McGuire VA Medical Center, Richmond, Virginia
Cheyenne VA Medical Center, Cheyenne, Wyoming
CAP Summary – Evaluation of Emergency Airway Management in Veterans Health Administration Facilities
CAP Summary – Evaluation of Safe Medication Storage Practices in Veterans Health Administration Facilities

Community Based Outpatient Clinic Reviews
In April 2016, OIG published eight Community Based Outpatient Clinic (CBOC) reviews containing OIG's findings at select CBOCs and primary care clinics that fall under the oversight of the parent facilities listed below. The purpose of the CBOC reviews was to evaluate four operational activities:

(1) Environment of Care
(2) Home Telehealth Enrollment
(3) Outpatient Lab Results Management
(4) Post-Traumatic Stress Disorder Care

Tuscaloosa VA Medical Center, Tuscaloosa, Alabama
Charlie Norwood VA Medical Center, Augusta, Georgia
Kansas City VA Medical Center, Kansas City, Missouri
Fargo VA Health Care System, Fargo, North Dakota
Eastern Oklahoma VA Health Care System, Muskogee, Oklahoma
Hunter Holmes McGuire VA Medical Center, Richmond, Virginia
Cheyenne VA Medical Center, Cheyenne, Wyoming
Sheridan VA Healthcare System, Sheridan, Wyoming

CRIMINAL INVESTIGATIONS

Pharmaceutical Manufacturer Warner Chilcott PLC Pleads Guilty to Health Care Fraud

The Department of Justice announced that Warner Chilcott U.S. Sales LLC, a subsidiary of pharmaceutical manufacturer Warner Chilcott PLC, pled guilty to health care fraud and was sentenced that same day. As part of a global settlement with the United States, the company agreed to pay $125 million to resolve its criminal and civil liability arising from the company's illegal marketing of the drugs Actonel, Asacol, Atelvia, Doryx, Enablex, Estrace, and Loestrin. VA purchased over $40 million of these drugs. As a result of this VA OIG, Federal Bureau of Investigation (FBI), Health and Human Services OIG, Food and Drug Administration Office of Criminal Investigations, Defense Criminal Investigative Service, and Office of Personnel Management OIG investigation, the company pled guilty to criminal charges that they committed a felony violation by paying kickbacks to physicians throughout the United States to induce them to prescribe its drugs, manipulating prior authorizations to induce insurance companies to pay for prescriptions of Atelvia that the insurers may not have otherwise paid for, and making unsubstantiated marketing claims for the drug Actonel. Under the terms of the agreement, the company will pay a $20.7 million criminal fine, $2 million criminal forfeiture, and has also entered into a civil settlement agreement under which it agreed to pay $102.06 million to the Federal Government and the states to resolve claims arising from its conduct, which allegedly caused false claims to be submitted to Government health care programs, including VA. Individuals charged to date in this health care fraud scheme include the former president of the company; two district managers, both of whom pled guilty; one district manager who also pled guilty; and a private physician. The investigation continues and criminal charges against other individuals are anticipated.

Business President Arrested for Conspiracy To Commit Wire Fraud

The president of a private business was arrested for conspiracy to commit wire fraud while attempting to fly to Guatemala. A VA OIG, FBI, and Department of Education OIG investigation revealed that the defendant engaged in a conspiracy to defraud VA by fraudulently obtaining tuition assistance and other education-related benefits under the Post 9/11 GI Bill. Over the course of the conspiracy, the defendant partnered with a New Jersey university to obtain approval from VA to receive tuition and other education benefits for several online non-credit training and certification courses. These courses were purportedly developed, taught, and administered by the faculty of the university, but were actually developed, taught, and administered by undisclosed and unapproved subcontractors of the private business. The defendant and others developed marketing materials and a script to be used by the private business' salespersons at various military bases around the United States in order to market to and enroll thousands of veterans in the courses. While most courses at the correspondence school cost between approximately $600 and $1,000 in tuition, the university charged between approximately $5,000 and $26,000 per course. Over the course of the conspiracy, the defendant and others caused VA to pay out over $35 million.

Architect Sentenced for Bribery of Former Director of the Cleveland and Dayton VA Medical Centers
An architect, formerly employed by a VA contractor, was sentenced to 33 months' incarceration, a $12,500 fine, and was ordered to forfeit $70,801 after being convicted at trial of conspiracy, wire fraud, mail fraud, theft of Government property, and violating the Hobbs Act. An OIG and FBI investigation revealed that the defendant bribed the former Director of the Cleveland and Dayton VA Medical Centers (VAMCs) in order to receive non-public information concerning VA contracts. As a result, the defendant was able to obtain an advantage over other companies in the awarding of VA contracts. The former VAMC Director pled guilty to corruption-related charges in 2014.

Two Non-Veterans Plead Guilty to Conspiracy To Commit Mail and Wire Fraud
Two non-veterans pled guilty to conspiracy to commit mail and wire fraud. A multi-agency investigation revealed an extensive surety bond fraud scheme that involved multiple Federal agencies and over $461 million in Government construction contracts. The defendants, along with other co-conspirators, used Government-owned lands or fraudulent trusts as assets to back bid, payment, and performance bonding while accepting over $8 million in bonding fees. The affected VA contracts totaled more than $97 million, including some American Recovery and Reinvestment Act funds.

Company Owner Indicted for Conspiracy To Commit Mail Fraud
The owner of three companies that contracted with various Government agencies was indicted for conspiracy to commit mail fraud. A multi-agency investigation revealed that beginning as early as February 2010 the defendant received numerous contracts from the Government, to include a VA contract, through FedBid.com. Once the subject companies received a contract from the Government, they arranged for victim-vendors to provide the goods to the Government. In order to induce the victim-vendors to agree to provide the goods and extend credit to the subject companies, the defendant made fraudulent representations regarding his companies' creditworthiness and association with the Government. As part of the conspiracy, the defendant and his co-conspirators falsely promised to pay the victim-vendors for the goods. The defendant and his co-conspirators subsequently failed to pay over 40 victim-vendors over $1 million for goods provided to the various Government agencies.

Former Ann Arbor, Michigan, VA Canteen Chief Sentenced for Theft
A former Ann Arbor, MI, VA canteen chief was sentenced to 15 months' incarceration, 2 years' supervised release, and was ordered to pay restitution of $314,400 after pleading guilty to Theft of Government Funds. An OIG investigation revealed the defendant used the stolen funds for gambling, prostitutes, and at adult entertainment clubs.

Former United States Postal Service Employee and Private Medical Clinic Administrator Plead Guilty to Conspiracy and Kickbacks
A former United States Postal Service (USPS) employee, who was also a union president, along with an administrator of a private medical clinic pled guilty to conspiracy and kickbacks. A VA OIG, USPS OIG, Department of Labor (DOL) OIG,

and Department of Homeland Security OIG investigation revealed that the former union official conspired with the clinic administrator to refer injured Federal employees, to include VA employees, to the clinic in order to receive care through the Federal Workers Compensation Program. The former union official received more than $1 million in kickbacks, $250,000 of which was funneled through his daughter, a legal assistant in the Hillsborough County, FL, public defender's office. The daughter, as well as the chief executive officer of the clinic, previously pled guilty to charges relating to this case.

Former Montrose, New York, VAMC American Federation of Government Employees President Pleads Guilty to Wire Fraud
A former Montrose, NY, VAMC American Federation of Government Employees president pled guilty to wire fraud and also agreed to pay $150,000 in restitution. An OIG and DOL Office of Labor Management Standards investigation revealed that the defendant used a union debit card to withdraw cash and pay for personal expenses.

Waco, Texas, VAMC Employee Arrested for Aggravated Sexual Assault
A Waco, TX, VAMC employee was arrested after being indicted for aggravated sexual assault. An OIG, VA Police Service, and local police investigation revealed that the defendant sexually assaulted a mentally challenged co-worker while at the medical center.

Veteran Arrested for Making Threats to San Diego, California, VAMC Employees
A veteran was arrested for influencing, impeding, or retaliating against a Federal official by threatening or injuring a family member. An OIG investigation revealed that the defendant, who was displeased with the way a VA doctor spoke to his wife, repeatedly left voicemail messages for the San Diego, CA, VAMC program support specialist and his supervisor who scheduled the exam. In the messages, the defendant said he was "in killing mode" and repeatedly threatened to kill the VA employees and their family members. The subject has a documented history of making similar threats to kill other Government employees. A 9mm handgun was found in the defendant's residence when he was arrested.

Veteran Arrested for Making Threats to Knoxville, Tennessee, VA Physician
A veteran was indicted and arrested for extortion and making threats toward his VA physician. An OIG investigation revealed that the defendant made several previous threats toward VA staff. In the most recent incident, the defendant contacted the VA Crisis Hotline and stated that he was going to murder his VA physician at the VA CBOC in Knoxville, TN, because she would not give him the amount of Hydrocodone he thought he needed. Three weapons were subsequently seized from the defendant's residence.

Non-Veteran Indicted for Theft of Government Funds and Aggravated Identity Theft
A non-veteran was indicted for theft of Government funds and aggravated identity theft. An OIG investigation revealed that the defendant assumed the identity of a veteran and began receiving VA health care and other services at the West Palm Beach, FL,

VAMC. The defendant met the veteran while living in Nashville, TN, and later assumed the veteran's identity after moving to southern Florida. In addition, the defendant failed to register as a sex offender stemming from the sexual assault of an 8-year-old child. The loss to VA is $68,655.

Veteran Pleads Guilty to Theft of VA Compensation Benefits
A veteran pled guilty to theft of public money. An OIG investigation revealed that in 1998 the defendant provided VA with a medical report from a non-VA ophthalmologist reporting that his visual acuity was "hand motion only," his vision would not get better, and that it could not be corrected by surgery. Based on this information, the defendant was rated 100 percent service-connected disabled for blindness. The investigation further revealed that the defendant possessed a valid driver's license, rode a motorcycle, and worked for 6 years as a mail clerk at a private business. A VA ophthalmologist recently examined the defendant and determined that he was not and could never have been blind. The loss to VA is $518,486.

Veteran Indicted for Theft of VA Compensation Benefits
A veteran was indicted for theft of Government funds related to the fraudulent receipt of disability compensation benefits for blindness. Following an OIG investigation, the defendant admitted to making multiple false statements over a 15-year period in order to obtain VA benefits related to her visual and mental health. The loss to VA is $395,596.

Veteran Arrested for Making False Statement to VA
A veteran was arrested after being indicted for making a false statement. An OIG investigation revealed that the defendant falsely claimed that he suffered from post-traumatic stress disorder caused by his deployment to Iraq. Military records revealed that the defendant received a General Discharge for Misconduct after 16 months of service and was never deployed overseas. The loss to VA is approximately $60,000.

Son of Deceased VA Beneficiary Indicted for Theft
The son of a deceased VA beneficiary was indicted for theft. An OIG investigation revealed that the defendant stole funds that were direct deposited after his father's death in July 2007 by forging the name of his deceased mother, who was still listed as a joint account holder. The loss to VA exceeds $300,000.

Friend of Deceased Veteran Beneficiary Sentenced for Theft of VA Benefits
The friend of a deceased veteran beneficiary was sentenced to 3 years' probation, during which the defendant must serve three 10-day sentences of incarceration and 9 months' home confinement. The defendant was also ordered to pay VA restitution of $265,483. An OIG investigation revealed that the defendant stole VA compensation benefits that were direct deposited after the veteran's death in April 2006.

Friend of Deceased VA Beneficiary Indicted for Theft of Government Funds
The friend of a deceased VA widow beneficiary was indicted for theft of Government funds. An OIG investigation revealed that the defendant stole VA funds that were direct deposited to a joint account after the widow's death in February 2008. The loss to VA is $127,288.

Daughter of Deceased Veteran Beneficiary Pleads Guilty to Theft of Government Funds
The daughter of a deceased veteran beneficiary pled guilty to theft of Government funds. An OIG investigation revealed that the defendant stole VA benefits that were direct deposited into the deceased veterans account after the veteran's death in August 2012. The loss to VA is $98,510.

Son of Deceased Dependency and Indemnity Compensation Beneficiary Pleads Guilty to Theft of Government Funds
The son of a deceased dependency and indemnity compensation beneficiary pled guilty to theft of Government funds. During an OIG investigation, the defendant admitted to not notifying VA of his mother's death in June 2008 and to using the stolen VA benefits for personal expenses. The loss to VA is $94,317.

Daughter of Deceased VA Beneficiary Sentenced for Theft of VA Benefits
The daughter of a deceased VA beneficiary was sentenced to 4 years' probation, 150 hours' community service, and was ordered to pay VA restitution of $61,469 after pleading guilty to the theft of public money. An OIG investigation revealed that the defendant stole VA funds that were direct deposited after her mother's death in November 2009.

Defendant Pleads Guilty to Mail Fraud
A defendant pled guilty to mail fraud. An OIG and U.S. Postal Inspection Service investigation revealed that the defendant utilized the mail to defraud veterans out of their VA benefits through the use of fraudulent businesses that were incorporated by the defendant to ostensibly assist veterans in applying for VA benefits. The defendant falsely represented that she was investing the veterans' VA funds in annuities. In addition to veterans, the defendant also defrauded other non-veteran senior citizens. The defendant embezzled approximately $2 million from both veterans and non-veterans.

Huntsville, Alabama, CBOC Medical Support Assistant Arrested for Attempting to Seduce a Child
A Huntsville, AL, CBOC medical support assistant was arrested for use of a computer service to seduce a child to commit an illegal act. An OIG, Georgia Bureau of Investigation, and local police investigation revealed that the defendant engaged in sexually explicit email correspondence from his VA computer in an attempt to engage in sexual activity with a police detective posing as a minor child. At the time of the defendant's arrest, OIG agents found pornographic images on his computer screen. The defendant was held pending extradition to Georgia.

Veteran Sentenced for Theft and Assault
A veteran was sentenced to 10 months' incarceration and 1 year of supervised release after pleading guilty to theft and assault. An OIG and VA Police Service investigation revealed that the defendant attempted to steal three North Face jackets from the Veterans Canteen Service at the Buffalo, NY, VAMC. While attempting to elude apprehension within the medical center, the defendant assaulted three veterans who were trying to stop him.

Former Bronx, New York, VAMC Pipefitter Sentenced for Drug Distribution
A former Bronx, NY, VAMC pipefitter was sentenced to 36 months' incarceration and 36 months' supervised release after pleading guilty to conspiracy to distribute and possession with intent to distribute cocaine. An OIG, U.S. Postal Inspection Service, VA Police Service, and Drug Enforcement Agency's New York Organized Crime Drug Enforcement Strike Force investigation revealed that six USPS Priority Mail parcels, each containing 1 to 2 kilograms of cocaine, were mailed to the defendant from Puerto Rico to a Bronx, NY, VAMC warehouse. Five defendants have been charged in this case, including two former VA employees.

Veteran Sentenced for VA Travel Benefit Fraud
A veteran was sentenced to 60 months' probation and was ordered to pay restitution of $10,878 after pleading guilty to false claims. An OIG investigation revealed that the Veteran filed approximately 115 false travel claims at the Spokane, WA, VAMC.

Fugitive Felon Arrested with Assistance of OIG
A veteran was arrested at the Sepulveda, CA, VA Ambulatory Care Center by the local police, with the assistance of OIG and the VA Police Service. The fugitive was wanted in Arizona for charges that included molestation of a child, sexual conduct with a minor, sexual assault, sexual abuse, indecent exposure, and public sexual indecency.

ADMINISTRATIVE SUMMARIES OF INVESTIGATION

OIG conducted extensive work related to allegations of wait time manipulation after the allegations at the Phoenix VA Health Care System in April 2014. Since that event and through FY 2015, OIG received numerous allegations related to wait time manipulation at VA facilities nationwide from veterans, VA employees, and Members of Congress that were investigated by OIG criminal investigators.

As OIG stated at Congressional hearings, at this time OIG has completed more than 77 criminal investigations related to wait times and provided information to VA's Office of Accountability Review for appropriate action. It has always been OIG's intention to release information regarding the findings of these investigations at a time when doing so would not impede any planned prosecutive or administrative action. OIG has begun a rolling publication of these administrative summaries of investigation by state so that veterans and Congress have a complete picture of the work completed in their state. The administrative summaries of investigation released in April are listed below. As other reviews are completed, they will be posted to the OIG public website.

You may view and download these administrative summaries of investigation by clicking on the link to our webpage at www.va.gov/oig/publications/administrative-summaries-of-investigation.asp and selecting the appropriate state.

Administrative Summaries Investigation (April 2016)	
Summary Number	**Location**
14-02890-258	West Haven, Connecticut, VA Medical Center
14-02890-262	Augusta, Georgia, VA Medical Center
14-02890-250	Durham, North Carolina, VA Medical Center
14-02890-292	Tulsa, Oklahoma, VA Outpatient Clinic
14-02890-248	White River Junction, Vermont, VA Medical Center
14-02890-237	Cheyenne, Wyoming, VA Medical Center and Fort Collins, Colorado, Multi-Specialty Outpatient Clinic

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